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Testimony of William I. McMillan, MBA CHE, Administrator/CEO Guam Memorial Hospital Authority

Guam Memorial Hospital is the sole civilian hospital serving the Territory of Guam, with 160,000 population. As such the people of Guam look to the Hospital to provide for their acute care needs. Unlike other communities, we have no choice in facilities, and unlike other facilities that can develop specialized service lines; Guam Memorial Hospital must cover all the bases as best we can.

The population on Guam, the 190,000 residents of Micronesia that also consider Guam a medical hub of sorts, have some health challenges that the Hospital tries to be sensitive to. Diabetes and End Stage Renal Disease, and Heart Disease are many times more prevalent in the region for reasons genetic and cultural, much the same as many Native American populations. Heart Disease and Cancer are the leading causes of death.

As the focus of this testimony is on the disparity between our local healthcare system and that of mainland communities let me just note the prevalence of our big three disease conditions; Diabetes, Heart Disease and Cancer and simply state that with Diabetes and Heart disease, Guamanians have a disproportionate share that only well planned and delivered preventative healthcare can address and improve. I want to focus my comments on disparity in the actual health care system, and in particular the hospital I manage.

As with most hospitals, uncompensated care is a major challenge. The Hospital's annual revenue is $100,000,000, but our cash budget is only $65,000,000. Nearly 40% of Guam Memorial Hospital's revenue is written off as uncompensated. One third of the island's population has no health insurance, or is covered under our local Medically Indigent Program. The Medically Indigent Program is locally funded by appropriation from Guam's General Fund and with only a $16,000,000 appropriation comes nowhere close to funding the cost of care for both hospital based care, and community based care. Like other Hospitals, we shift some of the cost of the uncompensated care to commercial payors, never a popular practice, and because of the size of the uncompensated care burden we are not able to completely shift the cost. Recent changes in the Compact of Free Association that our Congresswoman, Madeleine Bordallo worked on will help, and as part of our uncompensated care is generated by citizens from the Freely Associated States; Thirty percent (30%) of our births are derived from Chuuk citizens who come to Guam for care.

Guam Memorial Hospital participates in the Medicare program, and it is in Medicare reimbursement that a very specific, and remediable disparity occurs. While we participate in the Medicare program, we are not part of the prospective payment system, nor do we want to be part of the Prospective Payment System. We are cost reimbursed. However there is a TEFRA (Tax Equity and Fiscal Responsibility Act) cap on our reimbursement that causes us to lose between $1,500,000 to $2,000,000 per year in Medicare allowable costs that exceed the TEFRA limit. A practical solution would be to re-base our TEFRA cap. This is provided for in 42 CFR 413.4. A more preferable alternative would be to amend PL 97-248 to remove the TEFRA limit for Guam Memorial Hospital. An even better solution would be to declare Guam Memorial Hospital a Critical Access Facility and allow us the one hundred and one percent (101%) cost reimbursement given to Critical Access Facilities. The thinking behind the Critical Access Facility reimbursement understands that in many remote communities the economic conditions to support a hospital do not exist. CAF designation is targeted at very small hospitals in rural areas. While Guam Memorial Hospital is certainly larger than contemplated for CAF (we have 208 beds), and Guam's population density may suggest that parts of the island are urban, I can truthfully say that the hospital's we use for tertiary care are seven hours flight time away in Honolulu, and even longer for the cardiac referral centers in Los Angeles.

Our financial challenge creates disparity in other areas as well. In January we had to call on the cavalry from the Department of Health and Human Services to help with our Neonatal intensive Care Unit. At the time our unit had a capacity of four neonates, and in the middle of January the census climbed from two, to four, to six, passing though nine and ultimately hit twelve premature infants. Without the staff and equipment provided we literally had nowhere to turn to, and I'd like to extend our thanks to the Department, to Secretary Thompson and his staff, and RADM Ronald Banks. The challenge is this; NICU beds to live birth ratios for the United States are four per 1000 live births. GMHA had one per 1000 births. We now have four per 1000 live births. The acute care bed capacity is similarly strained. GMHA provides 1.1 beds per 1000 population, our peer group; Census District 9 averages 2 beds per 1000 population. Hospital spending in these states averages about $1,100 per capita according to the American Hospital Association. GMHA's spending is $406.

These figures describe our challenge. The island's only radiation oncology service went closed permanently due to damage in the last typhoon, we must send patients to Hawaii or beyond for radiation treatment. While we do have a cardiac catheterization lab in the hospital, its use is limited because there is no cardiac surgeon available and surgery is certainly more than one hour away. We have adequate dialysis services on the island, but a high rate of amputation for want of a wound care program. Island health insurance companies estimate they spend thirty percent (30%) of their premium revenue on off-island referrals. With approximately 100,000 individuals covered by commercial health insurance the exodus of cash exceeds $30,000,000 annually, more than enough for GMH to build an excellent oncology program, secure the services of a cardiac surgeon, implement a wound program, and pay the debt service for the financing needed to increase our bed capacity.

Because of our uncompensated care burden GMHA does not currently generate any retained income to fund capital purchases.

My colleagues from the Commonwealth of the Northern Marianas, and the Republic of Belau and I have spoken of the need for a regional resource for healthcare, for the same flight of cash and patients to tertiary centers in the Philippines, and Hawaii impacts the other Micronesian states, possibly even more than Guam. Were we able to make this a reality quality care, to the same standard as our mainland facilities could be delivered in situ. Our region could take care of its own, save for the most complex cases.

To this end we are searching for a medical school partner or partners to establish residency rotations on Guam for physicians in training in family practice. We are seeking partnerships to establish a fellowship in cardiac surgery. We have a strategic plan that has identified 107 federal funding sources, both grants and loan guarantees, predominantly from Health and Human Services and the Department of Agriculture to assist us in this ambitious, but needed effort. We are building the hospital's managerial infrastructure; for the first time in a decade, every member of the Hospital's senor management are fully qualified in their field, all with graduate educations. We are intensively recruiting nurse and allied health care practitioners for as much of a challenge there is to maintain the facilities for care, there is a challenge in finding qualified staff. The University of Guam offers a four year degree in Nursing, but graduates too few nurses to meet the Hospitals attrition rate. There is no other formal training for X-ray technologists, physical therapists, pharmacists and so on.

We rely heavily on foreign trained professionals, and the annual cap on the H1 visa program restricts us significantly. Were we able to make changes in the H1C visa program specifically for Guam we would be able to secure more of the needed professionals.

In closing I wish to thank the Honorable Dan Burton from Indiana's 5th District, and the members of the House Committee on Government Reform for this opportunity to address you, and I'd like to briefly repeat the key actionable recommendations I presented.

GMHA's Medicare reimbursement needs to be addressed. The most favorable remedy would be to recognize, and reimburse the hospital as a Critical Access Facility. At the very lease the TEFRA imposed cap on reimbursement needs to be rebased, or eliminated.

GMHA would benefit significantly if we were able to recruit foreign health care professionals under the H1B or H1C visa program. A separate quota for Guam under H1B and an exemption for the bed size and Medicare/Medicaid payor mix requirements under the H1C program is needed.

Finally, increased spending is needed to bring the Hospital's bed capacity and programmatic scope in line with the island's and regional needs. We have identified a number of funding sources within HHS, DOA and other agencies. Most of these are

competitive grants; some would rely on a specific appropriation. The current level of Hospital spending, at $406 per capita on Guam is inadequate to address the acute care of the island and the region.

Thank you all/